| | STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 A. BUILDING B. WING | | | COMPLETED 01/23/2012 | | | |
|-----------------------------------|--|---|----------|----------------------|--|---------|----------------------------|
| | PROVIDER OR SUPPLIE | | | 3801 OI | DDRESS, CITY, STATE, ZIP CO LD BRUCEVILLE RD BO INES, IN 47591 | | |
| (X4) ID PREFIX TAG F0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | State Licensure Survey Dates: 1 1/18, 1/19, 1/20, Facility Number Provider Number AIM Number: 1 Survey Team: Martha Saull, RI Carole McDanie Terri Walters, R Ann Marie Cray Census Bed Typ SNF: 23 SNF/NF: 101 Total: 124 Census Payor Ty Medicare: 23 Medicaid: 79 Other: 22 Total: 124 Stage 2 Sample: These deficienci | /11, 1/12, 1/13, 1/17, , 1/23/12 :: 000016 er: 155042 100291500 N TC el, RN N es (1/12/12) pe: | F00 | 00 | | | |
| LABORATO | RY DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SI | IGNATURI | | TITLE | | (X6) DATE |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000016

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155042 | A. BUILDING B. WING | 00 | COMPLETED 01/23/2012 |
|--------------------------|----------------------------------|--|---------------------|---|------------------------|
| FOX RID | PROVIDER OR SUPPLIEF | STORS LLC | 3801 O | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 13 NNES, IN 47591 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | (X5) E COMPLETION DATE |
| | Quality review 1 Williams, RN | /30/12 by Suzanne | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 2 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|---------------------|----------------------------------|---|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155042 | B. WING | | 01/23/2012 |
| | | <u> </u> | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | LD BRUCEVILLE RD BOX 136 | |
| FOX RID | GE HEALTH INVE | STORS LLC | | NNES, IN 47591 | |
| (X4) ID | CHMMADV | TATEMENT OF DEFICIENCIES | ID | <u> </u> | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION |
| TAG | ` | R LSC IDENTIFYING INFORMATION) | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE DATE |
| F0164 | | the right to personal privacy | 1110 | | DATE |
| SS=D | | of his or her personal and | | | |
| 00-5 | clinical records. | y or the or their percental arta | | | |
| | | | | | |
| | Personal privacy | includes accommodations, | | | |
| | medical treatmen | t, written and telephone | | | |
| | | personal care, visits, and | | | |
| | | y and resident groups, but | | | |
| | • | uire the facility to provide a | | | |
| | private room for e | ach resident. | | | |
| | Except as provide | ed in paragraph (e)(3) of this | | | |
| | | ent may approve or refuse | | | |
| | • | sonal and clinical records to | | | |
| | any individual out | | | | |
| | | | | | |
| | | ht to refuse release of | | | |
| | • | cal records does not apply | | | |
| | | t is transferred to another | | | |
| | | tion; or record release is | | | |
| | required by law. | | | | |
| | The facility must l | keep confidential all | | | |
| | | ined in the resident's | | | |
| | records, regardles | ss of the form or storage | | | |
| | methods, except | when release is required by | | | |
| | | r healthcare institution; law; | | | |
| | 1 | nt contract; or the resident. | | | |
| | Based on observ | ration, record review and | F0164 | By submitting the enclosed | 02/22/2012 |
| | interview, the fa | cility failed to ensure | | material we are not admitting t truth or accuracy of any specif | |
| | privacy during 1 | of 1 gastric tube | | findings or allegations. We | 10 |
| | medication adm | inistration and 2 of 2 | | reserve the right to contest the | ا د |
| | grooming observ | | | findings or allegations as part | |
| | | ng and hair care) | | any proceedings and submit | |
| | | , | | these responses pursuant to c | |
| | _ | dents randomly observed | | regulatory obligations. The fac | - |
| | ` | CD unit and EF unit). | | request that the plan of correc | |
| | Residents #2, #6 | 6, #97 | | be considered our allegation of | |
| | | | | compliance effective February 2012 to the annual licensure | 44 , |
| | Findings include | : | | survey conducted on January | 11. |
| | | | | 22.75, 35.133564 311 Garidary | • • • |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 3 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|----------------------|------------------------------|--------|------------|--|------------------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 155042 | B. WIN | G | | 01/23/2012 | |
| NAME OF D | DOMED OF CLIPPLIED | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 3801 OI | LD BRUCEVILLE RD BOX 136 | | |
| | GE HEALTH INVES | STORS LLC | | VINCEN | NNES, IN 47591 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | `` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION | ĺ |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | | DATE | |
| | | | | | 2012 through January 23, | | |
| | 1. Resident #66' | s clinical record was | | | 2012. F164 It is the practice | | |
| | reviewed on 1/18 | 3/12 at 11:05 A.M. Her | | | Willow Manor to always assu | | |
| | current January 2 | 2012 physician orders | | | that residents receive privacy during personal care. <i>The</i> | ′ | |
| | | re not limited to: Lortab | | | correction action taken for | | |
| | * | l tablet per peg tube | | | those residents found to be | | |
| | every six hours f | | | | affected by the deficient | | |
| | every six nours i | oi paiii. | | | practice include: Resident #2 | ? is | |
| | 0 1/10/12 : 10 | 15 4 34 1 1 1 2 1 1 1 | | | receiving services in a manner | | |
| | | :15 A.M., LPN #1 was | | | that enhances their privacy. | | |
| | | stering Resident # 66's | | | Resident #66 is receiving | | |
| | Lortab 5/500 mg | per peg tube. Resident | | | medications in a manner that promotes privacy. Resident #9 | 7 | |
| | #66 was sitting u | p in her bed in her room. | | | is receiving services in a mann | | |
| | Resident #66's pr | rivacy curtain had been | | | that enhances privacy. <i>Other</i> | | |
| | pulled between h | er and her roommate but | | | residents that have the | | |
| | - | view by the room door. | | | potential to be affected have | | |
| | | ed was the bed by the | | | been identified by: All resider | its | |
| | | | | | have been reviewed to assure | | |
| | | ng this treatment CNA | | | that each resident receives | | |
| | | om twice passing ice | | | services in a manner that | | |
| | | n and opening the room | | | enhances privacy. The measures or systematic | | |
| | | w of the room to the hall. | | | changes that have been put | | |
| | CNA #3 also ent | ered to assist Resident # | | | into place to ensure that the | | |
| | 66's roommate w | hich had opened the | | | deficient practice does not | | |
| | view of Resident | #66 to the hall way | | | recur include: All nursing staff | | |
| | | esidents were passing by. | | | has been in-serviced related to | | |
| | | r | | | providing privacy during any ty | ре | |
| | 2 On 1/19/12 at | 9:28 A.M., Resident # | | | of personal care or G-tube | | |
| | | sitting in her wheelchair | | | medication administration in accordance with facility policy. | | |
| | | _ | | | Via routine rounds and the Qua | | |
| | | of Hall D which had the | | | Assurance process, managem | - | |
| | | nt viewing. LPN # 2 was | | | staff will be observing for any | | |
| | | obby area of hall D at his | | | issues related to provision of | [| |
| | | esident #97's fingernails | | | privacy. Any issues observed | | |
| | of both hands. The | nis lobby area had | | | be immediately corrected. The | | |
| | residents and sta | ff of Hall D passing by. | | | corrective action taken to monitor performance to assu | ure | |
| | | | | | compliance through quality | 16 | |
| | | | | | Compliance unough quality | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SUR COMPLETE 01/23/20 | ED |
|--------------------------|---|---|---|--|-----------------------------------|---------------------------|
| | PROVIDER OR SUPPLIE | | 3801 C | ADDRESS, CITY, STATE, ZIP CO DLD BRUCEVILLE RD BC NNES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | RECTION OULD BE PPROPRIATE CO | (X5) OMPLETION DATE |
| | On 1/23/12 at 12:10 P.M., the Administrator and the Director of Nursing (DON) were made aware of the lack of privacy during peg tube treatment on 1/18/12 at 10:15 A.M., and the clipping of a residents's fingernails in the hall lobby area on 1/19/12 at 9:28 A.M. At this time the DON did not provide any information regarding privacy. | | assurance is:A Perform Improvement Tool has initiated that randomly residents related to proprivacy during care and medication pass. The E Nursing, or designee, wo complete this tool week monthly x3, and then quex3. Any issues identified immediately corrected. Quality Assurance Commercial review the tools at the semeetings with recommercial recompleted: February 2. | been reviews 5 vision of d Director of vill kly x3, uarterly ed will be The nmittee will scheduled endations he I be | | |
| | was observed caresident had wet brushing and fix in the doorway or residents across resident's own redependent resident | tring for Resident #2. The thair which the CNA was ting. This was being done of the room of two the hall from the com. Resident #2 was a tent who had been put in | | | | |
| | residents who li Resident #131 a both were in the CNA did not kn enter their room there and began wet hair. Reside spend most of ea her chair facing out into the hall. | the CNA. The two ved in that room were nd Resident # 152, and room at the time. The ock or ask permission to as she placed Resident #2 brushing and fixing the ent # 152 was observed to ach survey day seated in the doorway and looking . She watched the of Resident #2 throughout | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 5 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | DF CORRECTION IDENTIFICATION NUMBER: 155042 | A. BUILDING B. WING | COMPLETED 01/23/2012 |
|--------------------------|---|---|----------------------|
| | ROVIDER OR SUPPLIER GE HEALTH INVESTORS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | ; |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| | the process. Passersby also observed the care. They included two visitors, maintenance man #2 , a physical therapy staffer and the unit manager. | | |
| | Interview with CNA#10 at this time indicated she had chosen that location for grooming the resident to "move her away" from her own roommate, who wanted to sit in their doorway. | | |
| | 3.1-3(0) | | |
| | | | |
| | | | |
| | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 6 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MI | JLTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|-----------------------|--|------------|---|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED |
| | | 155042 | B. WIN | G | | 01/23/2012 |
| NAME OF E | PROVIDER OR SUPPLIEI | R | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | | LD BRUCEVILLE RD BOX 136 | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | | | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| F0241 SS=D | | oromote care for residents n an environment that | | | | |
| 33=D | | ances each resident's | | | | |
| | | ct in full recognition of his or | | | | |
| | her individuality. | G | l | | | |
| | Based on observ | ration, record review and | F02 | 41 | F241 | 02/22/2012 |
| | interview, the fa | cility failed to ensure a | | | It is the practice of Willow | |
| | resident's dignity | y was maintained for 1 of | | | Manor to always assure that | |
| | 22 residents revi | iewed for dignity in a | | | residents are respected and treated in a dignified manner | |
| | Stage 2 sample of | of 22. | | | | • |
| | | | | | The correction action taken to | for |
| | Resident #8 | | | | those residents found to be | |
| | | | | | affected by the deficient | |
| | Findings include | 7. | | | practice include: Resident #8 receives all services | |
| | 1 mamgs merade | | | | in a manner that enhances | es |
| | On 1/13/12 at 1 | P.M., Resident #8 was | | | dignity. | |
| | | ig down the C unit hall. | | | | |
| | | ~ | | | Other residents that have the | |
| | | ed ambulating with a | | | potential to be affected have | |
| | | slipper socks on her feet. | | | been identified by: All residents are receiving | |
| | · · | nursing assistant) was | | | services in a manner that | |
| | | the resident, holding a | | | enhances dignity. | |
| | 1 | ersonal clothing items in | | | | |
| | it. | | | | The measures or systematic | |
| | | was observed sitting in | | | changes that have been put | |
| | his wheelchair in | n the C unit hall. As | | | into place to ensure that the deficient practice does not | |
| | | CNA #1 passed the male | | | recur include: | |
| | resident, he state | ed to CNA #1 "She can't | | | All nursing staff has been | |
| | go out with no s | hoes on." CNA #1 then | | | in-serviced to assure that dign | ity |
| | said "I had to tal | ke them off cause she | | | is provided to each resident | |
| | peed on them." | During this interaction, | | | during care. Via routine round | IS |
| | - | or individuals were | | | and Quality Assurance monitoring, management will be | oe |
| | observed in the l | | | | observing for issues related to | |
| | | | | | dignity. Any issues will be | |
| | On 1/20/12 at 12 | 2 P.M., the clinical record | | | immediately corrected. | |
| | | vas reviewed. A MDS | | | The corrective action taken t | fo. |
| | 1 51 1155145111 110 1 | | i i | | ı ine corrective action taken t | .U I |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 7 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED |
|--|---|---|------------------|---|-------------------------------------|
| AND FLAN OF | CORRECTION | 155042 | A. BUILDING | 00 | 01/23/2012 |
| | | | B. WING STREET | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF PRO | OVIDER OR SUPPLIER | 1 | | LD BRUCEVILLE RD BOX 136 | |
| FOX RIDG | SE HEALTH INVES | STORS LLC | VINCE | NNES, IN 47591 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| | (minimum data s 10/7/11 and indictotal cognition so the resident was cognition. The Market resident was current of the resident was interviewed. The resident was interviewed the above interacting indicated CNA # | tet assessment) was dated cated the resident had a core of 9, which indicated of moderately impaired MDS also indicated the rently on a toileting asionally incontinent of P.M., the Administrator She was made aware of ction. The Administrator 1 should not have ed to the male resident as sident #8. | TAG | monitor performance to assucompliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to dignity. The Director Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedul meetings with recommendation as needed. The date the systemic change will be completed: February 22, 2012 | DATE Ire of will led led led les |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 8 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|--|----------------------|---|------------|----------------------------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155042 | B. WIN | IG | | 01/23/ | 2012 |
| NAME OF D | ROVIDER OR SUPPLIER | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVES | STORS LLC | | VINCE | NNES, IN 47591 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | · · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG F0254 | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCT) | | DATE |
| SS=C | linens that are in g | rovide clean bed and bath pood condition. | | | | | |
| | | ation and interview, the | F02 | 254 | | | 02/22/2012 |
| | facility did not pr | rovide adequate numbers | | | F254 | | |
| | of wash cloths ar | nd towels for resident | | | It is the practice of this facilit | ty | |
| | care on 4 of 4 un | its. This had the | | | to assure that there is clean bed and bath linens available | | |
| | | ct all 124 residents. | | | that are in good condition. | - | |
| | 1 | | | | . . | | |
| | Findings include | | | | The correction action taken | for | |
| | - | | | | those residents found to be | | |
| | On 1/12/12 at 10 | :15 A.M. anonymous | | | affected by the deficient practice include: | | |
| | | ed the 2 closets on (C D) | | | No specific residents were | | |
| | | h cloths or towels. The | | | identified. New towels and wa | ish | |
| | _ | taff run out of towels and | | | clothes were purchased by the | 9 | |
| | | have to go to another unit | | | facility | | |
| | or laundry to get | | | | Other residents that have the | 9 | |
| | | | | | potential to be affected have | | |
| | On 1/12/12 at 10 | :20 A.M., anonymous | | | been identified by: | | |
| | | Alzheimer's unit (A B) | | | All residents have the potentia | | |
| | | vere no towels or wash | | | be affected. Please see syste changes below for means to | m | |
| | | it. The CNA indicated | | | prevent reoccurrence. | | |
| | | owels and wash cloths in | | | | | |
| | - | st when they are needed | | | The measures or systematic | | |
| | | ow them from other units | | | changes that have been put | | |
| | | | | | into place to ensure that the | | |
| | - | to borrow "but the truth is | | | deficient practice does not recur include: | | |
| | | we have to, to get by. I | | | The facility has purchased nev | V | |
| | have cleaned up | BM with pillow cases." | | | towels and wash clothes. The | | |
| | 0.1/10/10 | 20.436 4 5 45 | | | will be a minimum of 3 Par | | |
| | | :30 A.M. on the E and F | | | available in the facility at all tir | nes. | |
| | | towels and 2 wash | | | The Housekeeping/Laundry Supervisor is responsible for | | |
| | | ets. CNA # 27 and #28 | | | assuring that linen par is | | |
| | - | dicated there were | | | adequate and that all linens ar | e in | |
| | - | g shortages and most of | | | good condition. The Laundry | | |
| | the linen was in t | the condition observed. | | | Department and Nursing Department has been in-serving | cod | |
| | | | 1 | | i Deballileni nas been in-servi | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 9 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|----------------------|--|------------|----------------------------------|--|---------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPLETED |
| | | 155042 | B. WIN | | | 01/23/2012 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | 3801 O | LD BRUCEVILLE RD BOX 136 | |
| | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | DATE |
| | | heloths available at that | | | related to assuring that any concerns related to linen | |
| | | dingly rough and | | | availability are brought to the | |
| | abrasive/ exfolia | ting to the touch. | | | attention of their respective | |
| | | | | | supervisors so that they can b | e |
| | · · | 1/12 at 11:15 A.M., CNA | | | dealt with appropriately. | |
| | # 29 and #30 ind | licated they ran out of | | | The corrective action taken t | ₆₀ |
| | towels and wash | cloths in the early | | | monitor performance to assi | · * |
| | morning "Just w | hen showers are going | | | compliance through quality | |
| | on" and "If we h | ave them there are never | | | assurance is: | |
| | enough." "We c | an get them later in the | | | A Performance Improvement | |
| | day from the lau | ndry but we are out when | | | Tool has been initiated that | -1114. |
| | we need them." | , and the second | | | randomly reviews linen available and condition. The tool | ollity |
| | | | | | specifically looks for linen | |
| | On the skilled ur | nit (G H I), on 1/12/12 at | | | availability and quality. The | |
| | | A # 31 indicated running | | | Administrator, or designee, will | II I |
| | - | shift and going to the | | | complete this tool weekly x3, | |
| | - | ashcloths. The CNA | | | monthly x3, and then quarterly x3. Any issues identified will be | |
| | | vas one wash cloth left of | | | immediately corrected. The | |
| | | | | | Quality Assurance Committee | will |
| | | ble to get from the | | | review the tools at the schedu | led |
| | _ | NA stated "It pays to start | | | meetings with recommendatio | ns |
| | | as you come to work, | | | as needed. | |
| | 1 | can use a corner of a big | | | The date the systemic chang | 105 |
| | towel." | | | | will be completed: | ,,,, |
| | On 1/12/12 of 11 | 20 AM two lounder | | | February 22, 2012 | |
| | | :30 A.M. two laundry | | | | |
| | | ney did their best to keep | | | | |
| | | g to the units but the linen | | | | |
| | | as they could supply it, | | | | |
| | _ | es staff were waiting at | | | | |
| | the door to get w | vashcloths and towels. | | | | |
| | On 1/12/12 at 11 | :45 AM the | | | | |
| | Administrator w | as informed of the | | | | |
| | shortages and pr | ovided samples of the | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 10 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | of correction identification number: 155042 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPLETED 01/23/2012 |
|--------------------------|---|--|---|----------------------|
| | PROVIDER OR SUPPLIER DGE HEALTH INVESTORS LLC | 3801 O | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 1: NNES, IN 47591 | 36 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| | washcloths and hand towels which were available. She indicated she did not know what kind of fabric softener was in use and she would secure additional supplies of those linens. 3.1-19(g)(4) | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

1

Facility ID: 000016

If continuation sheet

Page 11 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 | | | LDING | ONSTRUCTION 00 | (X3) DATE COMPL 01/23 | LETED | |
|---|---|---|----------|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIE | | <u> </u> | 3801 O | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 136 NNES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F0315 SS=D | assessment, the fresident who enter indwelling cathete the resident's clin that catheterization resident who is in receives appropriate to prevent urinary restore as much repossible. Based on observation record review, the provide supportion and incontinence reviewed for uring who met the critic incontinence. Resident #131 Findings included The clinical record reviewed on 1/2. The 8/18/11 adm Set Assessment indicated diagnoral anxiety, depressing astroesophagea urinary continent MDS indicated the episodes of uring least one episode indicated there here | ord of Resident #131 was 3/12 at 1:10 P.M. hission Minimum Data (MDS) of Resident #131 hisses of Alzheimer's, hion, diabetes mellitus and hil reflux disease. The hie resident had 7 or more her resident had 7 or more hary incontinence but at he of continent voiding. It had been no trial toileting held toileting, prompted | F03 | 15 | F315 It is the practice of Willow Manor to assure that our residents receive appropriate services and treatments to prevent urinary tract infectio and restore as much normal bladder function as possible The correction action taken at those residents found to be affected by the deficient practice include: Resident #131 has had a track completed related to incontine and receives services in a manner that promotes as much onormal bladder function as possible based on the assessment. Other residents that have the potential to be affected have been identified by: All residents that are identified having any incontinent episod have been reviewed and are receiving services in a manner that promotes as much bladdefunction as possible. | ns for king ence h d as es | 02/22/2012 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 12 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO LDING | ONSTRUCTION 00 | (X3) DATE S | ETED | |
|--|---|---|---------------------|----------------|--|---|--------------------|
| | | 155042 | B. WIN | | | 01/23/ | 2012 |
| | PROVIDER OR SUPPLIE | | | 3801 O | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| | On 8/11/11 ther Nursing Assessitool completed in the urinary incompleted indicated the restimes." The cat left blank. That printed in bold to COMPLETE A TRACKING." lacking of any to assessment of posteromination of continent with some continent with some continent with some checked and characteristics. | e had been an Admission ment and data collection prior to the above MDS. Intinence portion sident was "incontinent at egory of Risk Factors was assessment had direction type "IF INCONTINENT, 3 DAY BLADDER Documentation was racking for actual for the above MDS. The provide of | | | The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: At the time of admission/readmission, each resident will have an incontine assessment completed. Base on the assessment, if the resid has any incontinence, a 3 day bladder tracking will be implemented. Based on the bladder tracking, an individual program will be established if possible based on the residen ability to train. Each assessm will be updated and reviewed quarterly in correlation with the MDS assessment period. The nursing staff has been in-servirelated to incontinence trackin toileting, and incontinence care | ence dd dent ized t's ent e e c c g, e. | |
| | Assessment) wa It indicated the of urine. Docur indicate the bold bladder tracking On 11/18/11 the the resident was | (Quarterly Nursing s completed on 11/18/11. resident was incontinent mentation was lacking to ded direction for 3 day was then performed. • Quarterly MDS indicated always incontinent with ontinent voiding. | | | The corrective action taken to monitor performance to assic compliance through quality assurance is: A Performance Improvement Tool has been initiated that wi utilized to observe for the provision of incontinence care. The tool will review proper assessment with correlating interventions and proper incontinence care. The tool wi randomly review 5 residents to assure that proper intervention. | ll be | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|-------|---|-------------------------------|----------------------------|
| | | 155042 | B. WING | | | 01/23/ | 2012 |
| | PROVIDER OR SUPPLIE | | 38 | 01 OL | DDRESS, CITY, STATE, ZIP CODE D BRUCEVILLE RD BOX 136 NES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TA | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | service provision continence supp plan of care rem On 1/18/12 at 7: on the drug admindicated the residuretic Lasix 20 On 1/18/12 from the dependent rein her wheel charchange or position CNAs # 11 and resident to bed with observed. The rincontinent brief urine and the whole was noted to have the backs of thig lower buttocks, ammonia character CNA # 11 referring saying, " those as she looks pretty she gets sometime for that." CNA (Extra Protective thick coating over damp buttocks with the coat | a 9:00 A.M. to 1:45 P.M. sident was observed to sit ir without check or on change. At 1:45 P.M., #12 pivot transferred the while a student nurse aide esident's sweat pants and were saturated with neel chair seat had pooled waffle cushion. Upon d garments the resident we deep indentations on this, in gluteal folds and on There was a strong ter to the urine odor. The ed to the indentations on the indentations of the indentations of the urine of the care to the was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong ter to the urine odor. There was a strong term of the urine of the u | | | are in place related to the promoting as much bladder function as possible. The Director of Nursing, or designe will complete this audit weekly monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee review the tool at the schedule meeting following the completi of the tool with recommendation as needed. The date the systemic change will be completed: February 22, 2012 | will ed on ons | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 14 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 | | (X2) MI A. BUII B. WIN | DING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 01/23/2012 | | |
|--|---|---|------|---------------------|--|----|----------------------------|
| | PROVIDER OR SUPPLIER | | | 3801 OL | ODDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 136 INES, IN 47591 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | to cleanse skin, le cream to the clea | et it dry and then apply nsed skin. | | | | | |
| | history of urinary | ord review indicated a review infection, last o antibiotic series | | | | | |
| | on 1/20/12 at 9:1 the facility did not tracking for assesshe had been award data to assess a prontinence in the system. She indithinking the facility day detailed trackactually what the of a program. The undated Police | inator was interviewed 5 A.M. She indicated of actually do bladder ssment. She indicated are there was insufficient attern of incontinence/ facility data collection cated she had been ity needed to collect a 3 king in order to assess resident needed in terms cy and Procedure for and Bladder Habits | | | | | |
| | "Upon completic Bladder monitori summary should resident. Each re for 5 days upon a thereafter unless occurred. The re either Formal bla | on of 5 day Bowel and ang record, an evaluation/ | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 15 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042 | (X2) MU A. BUIL B. WING | DING | NSTRUCTION 00 | (X3) DATE COMPL 01/23 / | ETED |
|--------------------------|---|--|-------------------------------|---------------------|--|--------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIE | | | 3801 OI | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 136 NNES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | λΤΕ | (X5) COMPLETION DATE |
| | in C.N.A. flow in C.N.A. shou hour, toilet etc. 3. A checkmark every hour follow the C.N.A. com 4. If the resider | Id check resident every as usual 5 day period. shall be placed in the box owed by the signature of | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 16 of 39

| AND PLAN OF CORRECTION DENTIFICATION NUMBER: 156042 | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|---------------------|-----------------------------|----------------------------|---------------------|-----------------------------------|------------------|------------|
| NAME OF PROVIDER OR SUPPLIER FOX RIDGE HEALTH INVESTORS LLC (X3) ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES GENERATED ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICENCIES ID SUMMARY STATEMENT OF DEFICENCE ID SUMMARY STATEMENT OF DEFICENCES ID SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMMARY ID SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMMARY STATEMEN | AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | DING | 00 | COMPL | ETED |
| AME OF PROVIDER OR SUPPLIER FOX RIDGE HEALTH INVESTORS LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (PRECIDED BY FULL TAG REGULATORY OR ISC IDENTIFYED IN FORMATION) TAG REGULATORY OR ISC IDENTIFYED IN FORMATION) FO322 SS=D Sased on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (pg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. STREET ADDRESS, CTY, STATE, ZIP CODE 3801 | | | 155042 | | | | 01/23/2012 | |
| FOX RIDGE HEALTH INVESTORS LLC (X9)ID SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC (IDENTIFYING INFORMATION) TAG REGULATORY OR LSC (IDENTIFYING INFORMATION T | | | | D. WIIV | | ADDRESS CITY STATE ZIP CODE | | |
| FOX RIDGE HEALTH INVESTORS LLC IXA1D SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MIXTS REPERCISED BY FULL TAG FROJULATORY OR ISC IDENTIFYING INFORMATION) FO322 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. WINCENNES, IN 47591 Disputations reaction (CAS) PREFIX TAG TAG PROFIX TAG PROFIX TAGENCARCHORY ACTOROSHOLDDE (CAS) PREFIX TAG CARGICTIVE ACTOROSHOLDDE (CAS) PROFIX TAG CARGICTIVE ACTOROSHOLDDE (CAS) PREFIX TAG PROFIX TAG PROFIX TAG CARGICTIVE ACTOROSHOLDDE (CAS) PREFIX TAG PROFIX TAG PROFIX TAG CARGICTIVE ACTOROSHOLDDE (CAS) PREFIX TAG PROFIX TAG CARGICTIVE ACTOROSHOLDDE (CAS) PREFIX TAG PROFIX T | NAME OF P | ROVIDER OR SUPPLIER | | | | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO322 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PACE TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX T | FOX RID | GE HEALTH INVES | STORS LLC | | VINCENNES, IN 47591 | | | |
| F0322 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Tag CROSS-REFERENCED 10 THE APPROPRIATE DIDES AND CROSS-REFERENCED 10 THE APPROPRIATE DIDES AND CROSS-REFERENCED 10 THE APPROPRIATE DIDES AND CROSS AND | (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | | | i i |
| F0322 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. For a passed on the comprehensive assessment of a resident who is fed by a naso-gastric tube (pastrostory tube receive them in accordance with the facility policy. F1322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications in deficient practice of this facility to assure that residents who receive medications in described with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | PREFIX | * | | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Findings include: Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Findings include: Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The measures or systematic changes that have been put | | | | <u> </u> | TAG | DEFICIENCY) | | DATE |
| resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Fo322 F322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents at have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | • | | | | | |
| gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. F0322 F322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | SS=D | | = | | | | | |
| treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for I of I gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on I/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take I tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Footbase reviewed on I/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take I tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The measures or systematic changes that have been put | | | | | | | | |
| pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual > 60 ml; hold & notify physician. Findings include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | • | | | | | | |
| metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Fo322 F322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | | | |
| nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Fo322 F322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | | | |
| Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Fo322 It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | | | |
| record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | ļ | possible, normal e | eating skills. | Ţ | | Į | | l |
| medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. to assure that residents who receive medications per G-tube receive them in accordance with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | Based on observa | ation, interview and | F03 | 22 | - | | 02/22/2012 |
| medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via C-tube of those residents found to be affected by the deficient practice include: Resident #66 receives medications via C-tube Other residents that have the potential to be affected have been identified by: All residents are receiving their medications per G-tube with the facility policy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via C-tube in accordance with the facility policy. Other residents medications in accordance with the facility policy. All residents are receivent those receive them in accordance with the facility policy. | | record review, th | e facility failed to ensure | | | I - | _ | |
| (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | medication admi | nistration per gastric tube | | | | | |
| for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 secieves medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | I - | De | |
| administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | 4 0 | , , , , | | | | | |
| Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The correction action taken for those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | _ | | | | with the facility policy. | | |
| those residents found to be affected by the deficient practice include: Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. those residents found to be affected by the deficient practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | indonny observed. | | | The correction action taken to | for | |
| Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Practice include: Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | Resident #00 | | | | | | |
| 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Resident #66 receives medications via G-tube in accordance with the facility policy. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | affected by the deficient | | |
| 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The measures or systematic changes that have been put | | Findings include | : | | | practice include: | | |
| reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The measures or systematic changes that have been put | | | | | | | | |
| current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. Other residents that have the potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | 1. Resident #66' | s clinical record was | | | | | |
| included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | reviewed on 1/18 | 3/12 at 11:05 A.M. Her | | | accordance with the facility po | licy. | |
| included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. potential to be affected have been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | current January 2 | 2012 physician orders | | | Other residents that have the | ا م | |
| 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. been identified by: All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | _ | | | | | | |
| every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | | | | | I - | | |
| (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. medications in accordance with the facility policy related to checking of placement with G-tubes. The measures or systematic changes that have been put | | _ | | | | _ | r | |
| check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. The measures or systematic changes that have been put | | _ | * | | | | .h | |
| each feeding if residual > 60 ml; hold & notify physician. G-tubes. The measures or systematic changes that have been put | | ` | | | | | | |
| notify physician. The measures or systematic changes that have been put | | - | _ | | | | | |
| The measures or systematic changes that have been put | | _ | | | | G-lanes. | | |
| changes that have been put | | notity physician. | | | | The measures or systematic | | |
| | | | | | | _ | | |
| On 1/18/12 at 10:00 A.M., LPN #1 into place to ensure that the | | On 1/18/12 at 10 | :00 A.M., LPN #1 | | | | | |
| crushed Lortab 5-500 mg in 30 cc of deficient practice does not | | crushed Lortab 5 | -500 mg in 30 cc of | | | deficient practice does not | | |
| water to administer per gastric tube. LPN recur include: | | water to adminis | ter per gastric tube. LPN | | | | | |
| #1 indicated he would proceed to All nurses have been in-serviced | | | | | | | | |
| administer the medication by checking for related to checking of G-tubes placement prior to medication | | | • | | | _ | | |
| residual feeding. LPN #1 indicated he did administration in accordance with | | | | | | | with | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 17 of 39

| NAME OF PROVIDER OF SUPPLIER FOX RIDGE HEALTH INVESTORS LLC (X4) ID SUMMARY STATISHINGT OF DEPRCIPENCITS (PACT) DISTRICTENCY MIST HIS PERCEPSION FULL (TAG) REGULATORY OF LSC IDENTIFYING REFORMATION) not usually check for placement of the tube per auscultation per stethoscope. At this time, the Director of Nursing (DON) was made aware of LPN #1 not proceeding to check for placement of the gastric tube before medication administration. The DON indicated she wasn't sure of facility policy but would check. On 1/18/12 at 10:15 A.M., LPN #1 indicated the DON had indicated to use a stethoscope to check placement before medication administration. At that time LPN#1 got a stethoscope and checked placement before the Lortab was administered. On 1/18/12 at 10:18 A.M., a facility policy entitled "Enteral Tube Medication Administration" (no date) was received from the DON. The policy indicated, "Purpose: to safely and accurately administer on medications through an enteral tube." " Procedure 1. Pull privacy curtain, Glove hands, 2. If resident is bed, clevate head of bed to 45-degree angle, 3. Verify tube placement, a. Unclamp tube and use the following procedures: b. Insert a small amount of air into the tube with the STREET ADDRESS, CITY, STATL, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID PROVIDENT STATL, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID PROVIDENT STATL, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID PROVIDENT STATL, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 ID PROVIDENT STATL, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 The Corrective action state of COMPLETION DATE The floation policy for Enteral Tube Medication administration has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the OA process identified below. The corrective action take to machinistration administration and occur are policy for medication state of the Complete occur and the Complete oc | | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (COMPLET | | | | |
|--|--------|--|--|---|---------|---|---|------------|
| NAME OF PROVIDER OR SUPPLIER FOX RIDGE HEALTH INVESTORS LLC IX9-ID PREFIX IX0-D IX9-D IX | | | 155042 | | | | 01/23/ | 2012 |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 1 TAG REGULATORY OR LSC IDENTIFYING INFORMATION I TAG REGULATORY OR LSC IDENTIFYING INFORMATION I TAG REGULATORY OR LSC I | | | | | 3801 OI | LD BRUCEVILLE RD BOX 136 | | |
| tube per auscultation per stethoscope. At this time, the Director of Nursing (DON) was made aware of LPN #1 not proceeding to check for placement of the gastric tube before medication administration. The DON indicated she wasn't sure of facility policy but would check. On 1/18/12 at 10:15 A.M., LPN #1 indicated the DON had indicated to use a stethoscope to check placement before medication administration. At that time LPN#1 got a stethoscope and checked placement before the Lortab was administered. On 1/18/12 at 10:18 A.M., a facility policy entitled "Enteral Tube Medication Administration was received from the DON. The policy indicated in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. | PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| syringe and listen to stomach with stethoscope for gurgling sounds" | | not usually checked tube per auscultath this time, the Dirwas made aware proceeding to che gastric tube before administration. wasn't sure of farcheck. On 1/18/12 at 10 indicated the DO stethoscope to che medication administered. On 1/18/12 at 10 policy entitled "I Administration" from the DON. "Purpose: to safe administer oral renteral tube." " privacy curtain. resident is bed, each of the placement. a. Ur following proceed amount of air integringe and lister syringe and lister or all the placement. a. Ur following proceed amount of air integringe and lister or all the placement. a. Ur following proceed amount of air integringe and lister or all the placement. The privacy curtain amount of air integringe and lister or all the placement. The privacy curtain amount of air integringe and lister or all the placement. The privacy curtain amount of air integringe and lister or all the placement. | k for placement of the ation per stethoscope. At rector of Nursing (DON) of LPN #1 not eck for placement of the re medication. The DON indicated she cility policy but would. 2:15 A.M., LPN #1 2:15 A.M., LPN #1 2:20 A.M. at the context of the c | | | Enteral Tube Medication Administration has been place each MAR for quick access if needed by the nurses. Rando reviews will occur as part of th QA process identified below. The corrective action taken to monitor performance to assist compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents applicable) for proper medicate administration when G-tube is prescribed route of intake. The Director of Nursing, or designed will complete this tool weekly a monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedul meetings with recommendation as needed. The date the systemic change will be completed: | d in m e o ire (if ion the ee, c3, re) will led ins | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 18 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | of Correction identification number: 155042 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPI 01/23 | LETED |
|--------------------------|---|--|---|----------------|----------------------------|
| | PROVIDER OR SUPPLIER GE HEALTH INVESTORS LLC | 3801 O | ADDRESS, CITY, STATE, ZIP CODE ILD BRUCEVILLE RD BOX 1 NNES, IN 47591 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | On 1/20/12 at 12:55 P.M., during interview with the DON, she indicated nurses were to auscultate using stethoscope to check placement of gastric tube before administration of medications. She indicated she had laminated instructions (facility policy) for all residents with gastric tubes so nurses on all units had these instructions to refer to when administering medications per gastric tubes. 3.1-44(a)(2) | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 19 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE SUR | RVEY | |
|--|---------------------|---|--------------|-------------|---|----------|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | BB16 | 00 | COMPLETE | ED |
| | | 155042 | A. BUIL | | | 01/23/20 | 12 |
| | | | B. WIN | | ADDRESS SITY STATE TIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| FOY DID | | CTODS II C | | | NINES IN 47504 | | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE C | OMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0323 | | ensure that the resident | | | | | |
| SS=D | | ains as free of accident | | | | | |
| | | sible; and each resident e supervision and | | | | | |
| | | es to prevent accidents. | | | | | |
| , | ì | iew and record review, the | F03 | 23 | F323 | 10 | 2/22/2012 |
| | | ensure the resident was | 1 00. | | It is the practice of Willow to | | _,, _ 0 1 _ |
| | * | ate supervision to prevent | | | assure that residents receive | | |
| | | esidents reviewed for falls | | | adequate supervision to ass | ist | |
| | of 6 who met the | | | | with the prevention of falls. | | |
| | falls/accidents. | | | | The correction action taken | for | |
| | Resident #105 | | | | those residents found to be | | |
| | resident #103 | | | | affected by the deficient | | |
| | Eindings in slud | | | | practice include: | | |
| | Findings include | 5. | | | Resident #105 has been | -4- | |
| | 701 1: : 1 | 1 CD :1 / //105 | | | reviewed and has all appropriated fall prevention interventions are | | |
| | | ord of Resident #105 was | | | place in accordance with the p | | |
| | reviewed on 1/2 | | | | of care. | | |
| | | ded, but were not limited | | | | | |
| | to, the following | g: macular degeneration, | | | | | |
| | high risk for fall | ls, vascular dementia with | | | 041 | _ | |
| | behaviors, histor | ry stroke. The resident | | | Other residents that have the potential to be affected have | - | |
| | was admitted to | the facility on 11/18/11. | | | been identified by: | | |
| | The MDS (mini | mum data set assessment) | | | All residents have been review | ved | |
| | dated 11/25/11 i | indicated the following for | | | to assure that they are receiving | ng | |
| | the resident: To | otal summary score for | | | services in accordance with th | | |
| | | , which indicated severe | | | plan of care and assessed saf | - | |
| | 1 - | rment; walking in room | | | devices. The CNA assignmer sheets appropriately address | 11 | |
| | and corridor req | • | | | residents needs based on the | | |
| | | fer and bed mobility | | | assessment and a monitoring | | |
| | | assistance; balance | | | system has been implemented | d to | |
| | _ | and walking is not steady, | | | assure that interventions are | | |
| | _ | oilize with human | | | appropriately in place. | | |
| | | | | | The measures or systematic | | |
| | | mally used a walker | | | changes that have been put | | |
| | | ntinent; history of falls. A | | | into place to ensure that the | | |
| | RAP (resident a | ssessment protocol) dated | | | deficient practice does not | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 20 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE |) DATE SURVEY | |
|--|--|------------------------------|--------|----------|--|---------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUI | LDING | 00 | COMPL | ETED |
| | | 155042 | B. WIN | | | 01/23/ | 2012 |
| | | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | C | | 3801 O | LD BRUCEVILLE RD BOX 136 | | |
| | GE HEALTH INVES | | | | NNES, IN 47591 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓΕ | COMPLETION |
| TAG | . | LSC IDENTIFYING INFORMATION) | | TAG | recur include: | | DATE |
| | | ed the resident takes | | | The interdisciplinary team will | he | |
| | ` | medication) to help with | | | reviewing every fall to assure t | | |
| | · · | valker and assist of 1 - 2 | | | appropriate interventions are in | | |
| | | walking; uses antianxiety | | | place based on the possible | | |
| | and hypnotic me | edication. | | | cause of the fall. The plan of | | |
| | | | | | care and the CNA assignment | | |
| | A Fall Risk care | plan, dated 11/26/11, | | | sheets will be updated as needed. The nursing staff has | | |
| | included, but wa | s not limited to, the | | | been in-serviced related to | | |
| | following interve | entions: 12/14/11 bed | | | providing services to our | | |
| | | rm, ppa (personal | | | residents in correlation with the | е | |
| | ^ |) in wheelchair; 12/24/11 | | | written plan of care. The | | |
| | - | n alarms and not leaving | | | in-service also includes that residents that utilize alarms as | | |
| | resident unattend | • | | | safety device are not to be left | | |
| | resident unattene | ica. | | | unattended during care. There | | |
| | A. IDT (intendia | | | | will be routine monitoring via | | |
| | ` | sciplinary team) progress | | | rounds by nurses and nursing | | |
| | | 2/26/11 and indicated the | | | administration to assure that | -1 | |
| | | A (certified nursing | | | safety devices are in place and functional in accordance with t | | |
| | , - | etting res (resident) ready | | | residents' plan of care. | iic | |
| | | /11CNA unhooked res. | | | | | |
| | | as high risk for falls. | | | | | |
| | | d retrieved a gown. At | | | The corrective action taken t | | |
| | which time res s | lid from w/c (wheelchair) | | | monitor performance to assu | ıre | |
| | hitting head on c | eloset door. L (left) side | | | compliance through quality assurance is: | | |
| | head received he | ematoma" | | | A Performance Improvement | | |
| | | | | | Tool has been initiated that wil | l be | |
| | On 1/19/12 at 12 | 2:05 p.m., Unit Manager | | | utilized to randomly review 5 | | |
| | | erviewed. UM #1 | | | residents related to falls to ass | ure | |
| | ` ′ | ked Alzheimers Unit. | | | that all interventions were appropriately in place and that | | |
| | _ | e resident fell on 12/14/11 | | | new interventions were | | |
| | | ne indicated the resident | | | implemented as needed. Safe | ty | |
| | had fallen on another unit in the facility | | | | device placement and function | 1 | |
| | | was found on the | | | will be specifically identified or | | |
| | | UM #1 stated the | | | the monitoring form. The Dire | ctor | |
| | | | | | of Nursing, or designee, will complete this tool weekly x3, | | |
| | resident began to | decline and was moved | | | Complete this tool weekly X3, | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION OF CORRECTION 155042 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 01/23/2012 | | | |
|--------------------------|--|--|--|---------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIER DGE HEALTH INVESTORS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | | | |
| TAG | over to the locked Alzheimers unit on 12/21/11. UM#1 indicated when the resident was on the locked Alzheimers unit, Resident #105 had a PPA (personal protective alarm) in wheelchair /recliner and a pressure pad alarm in bed. UM #1 indicated on 12/24/11, CNA (certified nursing assistant) #2 had the resident in the bathroom, unhooked the safety alarm and moved out of reach of Resident #105, and she fell out of the chair which resulted in a hematoma on the side of her head. UM #1 stated she talked to CNA #2, and he stated "I knew better." UM #1 indicated she thinks the CNA walked across the room away from the resident. UM #1 indicated CNA #2 should not have left Resident #105 unattended, resulting in a fall. UM #1 indicated on admission, 11/18/11, the resident's fall risk score was a 15, indicating a high fall risk. On 1/19/12 at 12 P.M. a current copy of the facility policy and procedure for "Incident and Accident/Fall Policy" was received from the Administrator. This policy was dated 4/2011. This policy included, but were not limited to, the following: "residents that have a (sic) incident after admission will have interventions placed to prevent further occurrencesnurse must put appropriate | TAG | monthly x3, then quarterly x3. areas identified via the audit w be immediately corrected. The Quality Assurance Committee review the tool at the schedule meeting following the complet of the tool with recommendations as needed. The date the systemic change will be completed: February 22, 2012 | Any vill e will ed ion ons | | | |
| | interventions in place to prevent further | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 22 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155042 | A. BUILDING B. WING | 00 | COMPLETED 01/23/2012 | | | |
|--------------------------|----------------------|---|--|--|----------------------|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | new intervention | e will update staff as to s, care plans" | | | | | | |
| | 3.1-45(a)(2) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | 1 | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 23 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | JLTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|---------------------|---|-------------------|---------------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | DDIC | 00 | COMPL | ETED |
| | | 155042 | A. BUII B. WIN | | | 01/23/ | 2012 |
| | | | B. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVES | STORS LLC | | VINCENNES, IN 47591 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ГЕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0329 | | ug regimen must be free | | | | | |
| SS=D | • | drugs. An unnecessary | | | | | |
| | | hen used in excessive | | | | | |
| | | plicate therapy); or for | | | | | |
| | | n; or without adequate nout adequate indications | | | | | |
| | | e presence of adverse | | | | | |
| | | ich indicate the dose | | | | | |
| | • | f or discontinued; or any | | | | | |
| | combinations of th | · | | | | | |
| | | | | | | | |
| | · | ehensive assessment of a | | | | | |
| | | y must ensure that | | | | | |
| | | e not used antipsychotic | | | | | |
| | | n these drugs unless | | | | | |
| | | therapy is necessary to | | | | | |
| | - | ndition as diagnosed and e clinical record; and | | | | | |
| | | antipsychotic drugs | | | | | |
| | | ose reductions, and | | | | | |
| | - | ntions, unless clinically | | | | | |
| | contraindicated, in | an effort to discontinue | | | | | |
| | these drugs. | | l | ļ | | | |
| | | ew and record review, the | F03 | 29 | F329 It is the practice of Willow | | 02/22/2012 |
| | _ | ensure the resident had | | | Manor to assure that | | |
| | adequate justifica | ation for use of hypnotics | | | medications are only | | |
| | for 1 of 3 residen | its reviewed with | | | administered when necessar | y | |
| | hypnotics of 10 r | residents reviewed for | | | with proper supportive | - | |
| | medications. | | | | documentation. | | |
| | Resident #105 | | | | | | |
| | | | | | | | |
| | Findings include | <u>.</u> | | | | | |
| | i manigo merade | • | | | T he comments of the first of | • | |
| | D 11 : #405 | 1 1 1 | | | The correction action taken to those residents found to be | or | |
| | | clinical record was | | | affected by the deficient | | |
| | reviewed on 1/19 | | | | practice include: | | |
| | Diagnoses includ | led, but were not limited | | | Resident #105 no longer has | | |
| | to, the following: | : UTI (urinary tract | | | orders for a hypnotic medication | on. | |
| | | lar degeneration, high | | | ,, | | |
| | ,, | , , | | | Other residents that have the | è | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 24 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|------------------------------|--------------------------------|--------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED | | | COMPLETED |
| | | 155042 | B. WING 01/23/2012 | | | 01/23/2012 |
| | | | B. WIN | | ADDRESS OF STATE ZID CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | L | | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | 3801 OLD BRUCEVILLE RD BOX 136 | | | |
| FOX RID | GE HEALTH INVES | STORS LLC | | VINCE | NNES, IN 47591 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | risk for falls, vas | cular dementia. An | | | potential to be affected have | |
| | · · | data set assessment) | | | been identified by: | |
| | ` ` | | | | All residents that take hypnotic | > |
| | | ndicated the resident | | | medications have been review | /ed |
| | | medication. A RAP | | | to assure that they are | |
| | (resident assessn | nent protocol) for psych | | | appropriate and only | |
| | meds indicated: | Currently receiving | | | administered if necessary. | |
| | Ativan and Dalm | nane as ordered. | | | The management of the control of | |
| | | | | | The measures or systematic | |
| | Numana mataa da | ted 11/18/11 at 6 P.M., | | | changes that have been put into place to ensure that the | |
| | · · · · · · · · · · · · · · · · · · · | , | | | deficient practice does not | |
| | indicated the following: "admitted to facilityc (with) diagnosis of | | | | recur include: | |
| | | | | | The nurses have been in-servi | iced |
| | UTIunable to r | neet adl (activities of | | | related to the use of hypnotic | |
| | daily living)" | | | | medications. Hypnotic | |
| |) | | | | medications will not be utilized | 1 |
| | Nursa natas date | ed 11/19/11 at 2 A.M., | | | unless alternative interventions | s |
| | | | | | have been attempted and faile | ;d |
| | | owing: "Resident has | | | as indicated by the | |
| | been on call ligh | t many times this night | | | documentation. In addition, th | e |
| | for A (assistance |) to bathroom. Assist | | | interdisciplinary team will be | |
| | resident every tii | ne et (and) urinated small | | | reviewing physician orders each | |
| | amounts Says s | he can't sleep et wants to | | | business morning to assure th | at |
| | | ned of low back and | | | no new orders for hypnotic medication had been received | 1 |
| | | ned of low back and | | | inappropriately. Nursing | |
| | bladder pain" | | | | Management has also | |
| | | | | | established a binder that track | s |
| | Nurses notes dat | ed 11/20/11 at 3 A.M., | | | hypnotics for ongoing review for | |
| | indicated the foll | owing: "Resident has | | | reduction and elimination. | |
| | been up to bedsi | de commode several | | | | |
| | | has urinated several | | | The corrective action taken t | o |
| | times on the floo | | | | monitor performance to assu | ıre |
| | | 1 | | | compliance through quality | |
| | | 1.11/01/11 0 | | | assurance is: | |
| | | ed 11/21/11 at 3 A.M., | | | A Performance Improvement | |
| | indicated the foll | owing: "Resident has | | | Tool has been initiated that | |
| | been up to bedsi | de commode several | | | randomly reviews 5 residents | |
| | | | | | | ; |
| | | - | | | | |
| | | Resident only urinated a | | | related to hypnotic drug administration. The Director of Nursing, or designee, will | i |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 25 of 39

| | | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|-----------|--|--|-------------|------------|---|-------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | ILDING | 00 | COMPL | |
| | | 155042 | B. WIN | NG | | 01/23/ | 2012 |
| NAME OF I | PROVIDER OR SUPPLIEI | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF F | PROVIDER OR SUPPLIED | | | 3801 OI | LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCEN | INES, IN 47591 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| TAG | Nurses notes, da indicated the fol forDalmane insomnia" A physician order indicated the fol 15mgq (every) insomnia." A Pharmacy continuicated the fol additional documentation and the pharmacy of the pharmacy of the pharmacy of 1/19/12 at 12 manager) #1 was reviewed the restricted Resided due to insomnia documentation and diagnosis of successident's clinicate care plan addressident order indicated the following the fo | ted 11/21/11 at 2 P.M., lowing: "New order every night d/t (due to) er, dated 11/21/11, lowing: "Dalmane once (night) d/t (due to) sult dated 12/29/11 lowing: "Dalmane?" No mentation was observed or consultation form. 2:15 P.M., UM (unit is interviewed. She ident's clinical record and ent #105 was on Dalmane but indicated was lacking as to a h. UM #1 indicated the il record did not include a sing insomnia. | | TAG | complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedu meetings with recommendation as needed. The date the systemic change will be completed: February 22, 2012 | will led ns | DATE |
| | record of an asse | was lacking in the clinical essment of the resident's justification of the | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 26 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | TE SURVEY MPLETED 23/2012 |
|--------------------------|----------------------------------|---|--|--|-----------|---------------------------|
| | PROVIDER OR SUPPLIE | | 3801 O | ADDRESS, CITY, STATE, ZIP LD BRUCEVILLE RD E NNES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE REGULATORY O | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | initiation of the Dalmane. | sleep medication | | | | |
| | 3.1-48(b)(2) | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 27 of 39

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155042 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 01/23/2012 | | |
|---|--|--|---------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER FOX RIDGE HEALTH INVESTORS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| F0356 SS=C The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses Licensed practical nurses or licensed vocational nurses (as defined under State law) Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the | F0356 | F356 | 02/22/2012 | | |
| facility failed to post nursing staffing information, including facility name and resident census, prominently with access to residents and visitors. This had the potential to affect all residents and visitors to the facility. | | It is the practice of Willow Manor to post nursing staffir information in accordance w the regulatory requirements. The correction action taken t those residents found to be affected by the deficient practice include: | ith | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 28 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|----------------------|------------------------------|------------|-------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIIII | DING | 00 | COMPLETED | |
| | | 155042 | A. BUII | | | 01/23/2012 | |
| | | | B. WIN | | ADDRESS SITY STATE ZID CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | |
| | Findings include | 2: | | | No specific residents were | | |
| | | • | | | identified. The facility format f | or | |
| | 0 1/11 10 12 | 17 10 10 122/12 4 | | | posting has been changed and | d | |
| | | 17, 18, 19, and 23/12 the | | | now reflects all regulatory | | |
| | | was observed between | | | requirements and is posted or | 1 | |
| | 9:30 A.M. and 1 | 0:00 A.M., to be posted | | | each unit. | | |
| | on the skilled un | it, near the entry door. | | | | | |
| | | ked the name of the | | | Other residents that have the | | |
| | facility and the r | | | | potential to be affected have | ! | |
| | lacinty and the i | esident census. | | | been identified by: All residents could potentially | ha | |
| | | | | | affected. Please see systema | • | |
| | | was located at the | | | changes below to prevent | luc | |
| | furthest distance | to the left from the main | | | reoccurrence | | |
| | entrance which v | was located in the | | | recodurence | | |
| | building center v | with wings on each side. | | | The measures or systematic | : | |
| | _ | nsus was between 120 and | | | changes that have been put | | |
| | | ys and the building | | | into place to ensure that the | | |
| | ľ | • | | | deficient practice does not | | |
| | | 5. The building had 4 | | | recur include: | | |
| | units, each with | separate entrances. The | | | The facility format for nursing | | |
| | posting was not | accessible to 3 units. | | | staff posting has been altered | | |
| | | | | | reflect the facility name and th | • | |
| | On 11/23/12 at 1 | 0:58 A.M., Employee | | | census in accordance with the | ; | |
| | | list #1 (responsible to | | | regulation. The Staffing | | |
| | _ | | | | Coordinator is responsible for posting the staffing and has | | |
| | _ | tion) was interviewed. | | | received in-servicing related to | , | |
| | | e posted the information | | | the required information as we | | |
| | daily at the one | location and did not | | | as posting at each nurses' | | |
| | realize the facilit | ty name and census were | | | station. | | |
| | lacking. She rec | called at one time before | | | | | |
| | _ | deling and merger of | | | The corrective action taken to | | |
| | 1 | wo distinct physical | | | monitor performance to assu | ure | |
| | | | | | compliance through quality | | |
| | _ | osting had been included | | | assurance is: | | |
| | on all units. | | | | A Performance Improvement | | |
| | | | | | Tool has been initiated that | | |
| | 3.1-13(a) | | | | randomly reviews for proper | | |
| | | | | | posting of nurse staffing in accordance with the regulation | , | |
| | | | | | The Director of Nursing, or | 1. | |
| | I | | | | I THE DIFFERENCE OF INGISHING, OF | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 | | A. BUILDING B. WING | 00 | COMPLETED 01/23/2012 | | | | |
|---|---------------------|---|---|--|----------------------|--|--|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| FOX RID | GE HEALTH INVES | STORS LLC | 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | | | | designee, will complete this to weekly x3, monthly x3, and the quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will revithe tools at the scheduled meetings with recommendatio as needed. The date the systemic chang will be completed: February 22, 2012 | ew ns | | | |
| | | | | 1 ebitally 22, 2012 | | | | |
| | | | | | | | | |
| | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 30 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|--|--|----------------|---------------------|--|------------|---------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| | | 155042 | B. WIN | | | 01/23/2012 | |
| NAME OF B | AD CLUBED OD GUIDDUED | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 3801 O | LD BRUCEVILLE RD BOX 136 | | |
| | GE HEALTH INVES | STORS LLC | | | NNES, IN 47591 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | CROSS-REFERENCED TO | | E | LETION ATE |
| F0363 | | the nutritional needs of | + | TAG | BELIEBRELI | DE | AIE |
| SS=B | residents in accord | | | | | | |
| | | tary allowances of the | | | | | |
| | | Board of the National | | | | | |
| | Research Council, National Academy of Sciences; be prepared in advance; and be | | | | | | |
| | followed. | ared in advance, and be | | | | | |
| | Based on observa | ation, record review and | F03 | 63 | F363 | 02/2 | 2/2012 |
| | interview, the fac | cility failed to prepare | | | It is the practice of Willow | | |
| | meals according | to menu and recipe | | | Manor to prepare meals in accordance with the menus | | |
| | during 2 of 2 me | al preparation | | | and the recipes. | | |
| | observations inve | olving 2 cooks in 2 | | | | | |
| | separate kitchens | s, which had the potential | | | The correction action taken t | or | |
| | to affect 117 resi | dents who received food | | | those residents found to be | | |
| | from the two kits | chens of 124 residents in | | | affected by the deficient practice include: | | |
| | the facility. | | | | No specific residents were | | |
| | j | | | | identified. The menus and | | |
| | Findings include | : | | | recipes are currently being | | |
| | C | | | | followed in accordance with th | е | |
| | On 1/11/12 at 10 | :29 A.M., Cook #1 was | | | regulation. | | |
| | observed prepari | ng the noon meal for 74 | | | Other residents that have the | • | |
| | residents residing | g in the upper area of the | | | potential to be affected have | | |
| | facility. She coo | ked country fried steak | | | been identified by: Potentially all residents could be | | |
| | rather than count | ry fried chicken as | | | affected. Please see systema | | |
| | menued. She inc | licated she had read the | | | changes below to prevent | | |
| | menu incorrectly | when informed and then | | | reoccurrence. | | |
| | prepared the chic | eken instead, per menu. | | | | | |
| | The menu poste | d for resident anticipation | | | | | |
| | was for country | fried chicken. | | | | | |
| | The menu called | for Harvard beets, which | | | The measures or systematic | | |
| | she prepared from | n a recipe in the facility | | | changes that have been put | | |
| | recipe book. The | e beet recipe ingredients | | | into place to ensure that the deficient practice does not | | |
| | | sliced medium beets | | | recur include: | | |
| | including liquids | , ground cloves, sugar, | | | All dietary staff has been | | |
| | | arine, and distilled | | | in-serviced related to following | of | |
| | | | | | the menus and recipes. The | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 31 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|------------------------------|-------------------------|--------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETE | | | COMPLETED |
| | | 155042 | B. WIN | | | 01/23/2012 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | LD BRUCEVILLE RD BOX 136 | |
| FOX RID | GE HEALTH INVES | STORS LLC | VINCENNES, IN 47591 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | ID | DROWING BY AN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | vinegar. The coo | ok used pickled beets for | | | menus are established with | |
| | _ | en included the mixture | | | correlating recipes as approve | |
| | | ended for plain beets. | | | by the Registered Dietician. Th | ne |
| | 01 504501111155 1111 | ended for plain occis. | | | Dietary Manager will be responsible for assuring that the | |
| | On 1/11/12 at 10:50 A.M., Cook # 2 was observed preparing the noon meal for 48 | | | | appropriate products are in pla | |
| | | | | | to assure that the recipes can | |
| | | | 1 | | followed. See below for | |
| | | g in the lower facility. | | | monitoring to assure recipes a | re |
| | | d Harvard beets. She did | | | being followed. | |
| | not use the facility recipe as above. She used the appropriate amount of beets. She did not use plain beets as intended in the recipe but pickled beets. She | | | | The serve of the section follows | |
| | | | | | The corrective action taken t monitor performance to assu | |
| | | | | | compliance through quality | |
| | | | | | assurance is: | |
| | thickened the liq | uids from the beets with | | | A Performance Improvement | |
| | an unmeasured a | mount of cornstarch and | | | Tool has been initiated that | |
| | water mixture ap | proximately 2 cups water | | | randomly reviews 5 meals to | |
| | _ | starch. The recipe called | | | verify the menus and recipes were followed. The Dietary Manager, or designee, will | |
| | _ | rtions of beets, cloves, | | | | |
| | _ | , margarine and vinegar | | | complete this tool weekly x3, | |
| | | of servings. The cook | | | monthly x3, and then quarterly | |
| | | 2 ten pound cans" of | | | x3. Any issues identified will b | e |
| | | ated she chose that | | | immediately corrected. The Quality Assurance Committee | will |
| | | | | | review the tools at the schedul | |
| | | "That's what I always use | | | meetings with recommendation | |
| | and it comes out | about right." | | | as needed. | |
| | On 1/20/12 at 12 | :50 P.M., the Food | | | The date the systemic chang | res |
| | | was interviewed and | | | will be completed: | |
| | | not buy plain beets since | | | February 22, 2012 | |
| | | | | | • | |
| | | pickled beets tasted better | | | | |
| | | ngs for the plain beets. | | | | |
| | | e had not discussed the | | | | |
| | | r relative nutritional | | | | |
| | impact with the | consultant dietician. | | | | |
| | 3.1-20(i)(4) | | | | | |
| | J.1-20(1)(1) | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 32 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE COMPI 01/23 | LETED | | |
|--------------------------|--------------------------------------|---|--|--|---|-------|--|--|
| | ROVIDER OR SUPPLIE GE HEALTH INVE | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 33 of 39

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 NAME OF PROVIDER OR SUPPLIER FOX RIDGE HEALTH INVESTORS LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | ED 012 | | |
|---|--|---|-----|---------------------|---|--|----------------------------|
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE (| (X5) COMPLETION DATE |
| F0371 SS=F | considered satisfa local authorities; a (2) Store, prepare under sanitary cor Based on observation facility failed to in meal preparation the areas of kitch service, during 2 the potential to a received food from the 124 residents. Findings include 1. On 1/11/12 at the upper kitcher was observed. The hand washin brown stain and scraped off with at the back of the accumulated brown in crevices. There were 2 ski # 1 indicated the only one of that a Both skillets had surfaces and dries. | distribute and serve food diditions ation and interview, the provide sanitary practices on and food storage and aren food processing and of 2 kitchen tours, with affect 117 residents who om the facility kitchens of residing in the facility. 10:29 A.M., the tour of a during food preparation are sidue which could be a fingernail. The caulk are sink was jagged and had we and dark gray matter and dark gray matter the size available for use. flaking nonstick interior | F03 | 71 | F371 It is the practice of Willow Manor to assure that sanitar practices are in place related food storage and preparation The correction action taken those residents found to be affected by the deficient practice include: No specific residents were identified. The areas identified the 2567 have been corrected follows: The hand washing sink has be cleaned and re-caulked. The 2 skillets have been clear The food prep surfaces are no being sanitized. The beverage/dairy refrigerate that has had a broken thermometer now has 2 thermometers on the inside. The iron skillet and small aluminum skillet have been replaced. The binder for recording food temperatures has been replace The white wall under the soap dispenser has been cleaned. The red bucket by the hand washing sink has been cleaned. The microwave has been cleaned. Other residents that have the potential to be affected have | y d to n. for d in d as een ned. ow or | 02/22/2012 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE SURVEY |
|--|---------------------|--------------------------------|--------|------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 155042 | B. WIN | | | 01/23/2012 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | LD BRUCEVILLE RD BOX 136 | |
| FOX RID | GE HEALTH INVE | STORS LLC | | | NNES, IN 47591 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | to drop a thermo | ometer on the floor and | | | been identified by: | |
| | return it to the c | leaned food contact | | | All residents could potentially I | |
| | surface. She late | er wiped the thermometer | | | affected. Please refer below to systematic changes to prevent | |
| | | pad but did not sanitize | | | reoccurrence | • |
| | the food prep su | _ | | | recedantine | |
| | the rood prep su | Truce. | | | The measures or systematic | |
| | The harmon and de | f | | | changes that have been put | |
| | _ | niry refrigerator had a | | | into place to ensure that the | |
| | _ | nermometer on the outside | | | deficient practice does not | |
| | door. Inside the | | | | recur include: | |
| | | nich read 44 degrees at | | | All dietary staff has been in-serviced related to following | |
| | 11:30 A.M. Die | etary staff #1 indicated she | | | the cleaning schedule which | |
| | took and recorde | ed the refrigerator | | | includes the areas mentioned | in |
| | temperature. Sh | ne was unable to read the | | | the 2567 as well as assuring the | |
| | - | ting she had trouble | | | cookware is without pitting or | |
| | | s unsure how many | | | rusting. Maintenance will be | |
| | _ | between black lines. She | | | reviewing food preparation for | |
| | • | boboard on which she had | | | areas that may need re-caulking | ng |
| | - | • | | | as part of preventive maintenance. The Dietary | |
| | _ | erature of 38 degrees | | | Manager is responsible for | |
| | | . Later in the day for | | | assuring that the cleaning | |
| | - | :50 P.M. and 1:20 P.M. | | | schedule is followed, the | |
| | _ | erator was unopened, the | | | cookware remains appropriate | , |
| | thermometer ins | side continued to read 44 | | | and that the food preparation | |
| | degrees. | | | | area is maintained in a sanitar | у |
| | | | | | condition. | |
| | 2. In the lower l | kitchen during food | | | The corrective action taken t | |
| | | 1:45 A.M., the following | | | monitor performance to assu | |
| | was observed: | i. 13 71vi., the following | | | compliance through quality | |
| | was ouserveu. | | | | assurance is: | |
| | | 1.31 | | | A Performance Improvement | |
| | | on skillet stored as clean | | | Tool has been initiated that | |
| | • | l interior surfaces and rust | | | randomly reviews storage and | |
| | | the pitting. There was a | | | preparation of food to assure t sanitation practices are in place | |
| | small aluminum | skillet stores for use. It | | | The Dietary Manager, or | , C. |
| | had a nonstick in | nside surface which was | | | designee, will complete this to | ol |
| | pitted and flakin | ng off. | | | weekly x3, monthly x3, and the | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---------------------|--|----------------------------|----------------|---|------------------|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | A. BUILDING 00 | | COMPLETED | |
| | | 155042 | B. WIN | IG | | 01/23/2 | 2012 |
| NAME OF F | PROVIDER OR SUPPLIE | ER. | _ | | ADDRESS, CITY, STATE, ZIP CODE | - | |
| | | | | | LD BRUCEVILLE RD BOX 136 | | |
| FOX RID | GE HEALTH INVE | STORS LLC | | VINCE | NNES, IN 47591 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | , | NCY MUST BE PERCEDED BY FULL B. L. S.C. IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | REGULATORTO | R LSC IDENTIFYING INFORMATION) | | TAG | quarterly x3. Any issues | | DATE |
| | The feed temps | return recording book was | | | identified will be immediately | | |
| | _ | erature recording book was | | | corrected. The Quality | | |
| | | vith dried food matter and | | | Assurance Committee will rev | iew | |
| | | de surfaces. It was laying | | | the tools at the scheduled meetings with recommendation | ine | |
| | on a clean food | i prep surface. | | | as needed. | 115 | |
| | There was deep | lark brown matter on the | | | | | |
| | 1 | er the soap dispenser by | | | The date the systemic chang | ges | |
| | | had been smeared there. | | | will be completed: February 22, 2012 | | |
| | life Shik which | nad been sineared there. | | | 1 Columny 22, 2012 | | |
| | The red trach by | acket by the hand washing | | | | | |
| | | ulated food matter on the | | | | | |
| | | which had black growth | | | | | |
| | | surface and a mildew | | | | | |
| | odor. | surface and a mindew | | | | | |
| | odor. | | | | | | |
| | The microwaya | door was tacky with | | | | | |
| | | ly matter hand soil. | | | | | |
| | | ry matter name som. | | | | | |
| | On 1/20/12 at 1 | 2:50 P.M., the Food | | | | | |
| | | er was interviewed. She | | | | | |
| | _ | eas which needed cleaning | | | | | |
| | | and been on routine | | | | | |
| | | n and would be re-cleaned | | | | | |
| | 1 | een reinserviced on reading | | | | | |
| | | She indicated the | | | | | |
| | | h the broken digital | | | | | |
| | _ | d 2 interior dial | | | | | |
| | thermometers in | | | | | | |
| | | | | | | | |
| | 3.1-21(i)(3) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 1 | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 36 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 NAME OF PROVIDER OR SUPPLIER | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE COMPLE 01/23/2 | | ETED | | | |
|---|--|--|-------|------------------|--|----------------|----------------------------|
| FOX RID | GE HEALTH INVES | STORS LLC | | | LD BRUCEVILLE RD BOX 136 INES, IN 47591 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PRI | D EFIX 'AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F0518 SS=F | emergency proced work in the facility procedures with exunannounced staff procedures. Based on observative record review, the 4 of 4 laundry state perform fire emelaundry. This had the pote residents residing. Findings include On 1/23/12 at 11 Staffers #1 and # clothes during the processing. Neith they would do in Staff #1 indicated someone what to she didn't know, indicated the dry three employees any procedure to the event of a fire would call maint. Maintenance State indicated the gas would come from | ation, interview and e facility failed to ensure aff were prepared to rgency procedures in the ential to impact all g in the facility. :: :25 A.M., Laundry 2 were at work folding e dryer cycle of her was able to say what case of a dryer fire. d she would have to ask do. Staff #2 indicated The Laundry Supervisor ers were gas dryers. The were not familiar with shut off gas supply in e. Staff #1 said she enance to do that. | F0518 | | F518 It is the practice of Willow Manor to assure all staff is educated related to emergen procedures. The correction action taken is those residents found to be affected by the deficient practice include: No specific residents were identified. The staff identified been in-serviced related to emergency procedures. Other residents that have the potential to be affected have been identified by: Potentially all residents could affected. Please see below fo systematic changes to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All staff has been in-serviced related to information on emergency procedures including as shut off. Random interviewith staff will occur to assure to knowledge of emergency procedures as part of the QA process. | for has be r t | 02/22/2012 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 37 of 39

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION OO | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------------------|-----------------------------------|---|---|
| 155042 | | A. BUI B. WIN | LDING IG | | 01/23/2012 | |
| AND PLAN | PROVIDER OR SUPPLIED OF CORRECTION PROVIDER OR SUPPLIED OF CACH DEFICIENT REGULATORY OF CONTROL OUTSIDE CONTR | R STORS LLC STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) Upon observation of the in the back of the facility, is coated with paint and ever to have been moved. Would require a special e would have to get from the department. He all require quite a lot of most women could not a gas valve for each dryer from behind the wall on the swere installed. The cured by heavy layers of the sible except by ladder or in were not provided. He was not an actual plan for ption during a fire from of inservicing of all 4 vailable, however the fills were not specific to | A. BUI | LDING IG STREET A 3801 O | ADDRESS, CITY, STATE, ZIP CODE LD BRUCEVILLE RD BOX 136 NNES, IN 47591 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The corrective action taken to monitor performance to assist compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly interviews 5 staff members related to knowledge emergency procedures. The Administrator, or designee, wi complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will to immediately corrected. The Quality Assurance Committee review the tools at the schedu meetings with recommendation as needed. The date the systemic chang will be completed: February 22, 2012 | COMPLETED 01/23/2012 (X5) COMPLETION DATE To ure e of II // De will led ns |
| | there was not a | Policy or Procedure for ry but the facility was | | | | |
| | 1 | | 1 | | | 1 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet

Page 38 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/23/2012 | | | | | |
|---|---------------------|---|--|---|----------------------|--|--|
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| | | , | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RC6711

Facility ID: 000016

If continuation sheet Page 39 of 39